

JOHNS HOPKINS

U N I V E R S I T Y

School of Medicine

Johns Hopkins Geriatrics Center
Johns Hopkins Bayview Medical Center
5505 Hopkins Bayview Circle
Baltimore, MD 21224
(410) 550-2654 / FAX (410) 550-2513

Division of Geriatric Medicine and Gerontology

Bruce A. Leff, M.D..
Professor of Medicine

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United States Senate Committee on Finance
Hon. Orrin Hatch, Chairman
Hon. Ron Wyden, Ranking Member

RE: Comments on Bipartisan Chronic Care Working Group Policy Options Document

We are pleased that the United States Senate Committee on Finance has developed the Bipartisan Chronic Care Working Group Policy Options Document and has asked for comments on specific issues identified in their January 2015 document.

Background

We write to you as leaders of The National Home-Based Primary Care and Palliative Care Network. Our stakeholder Network consists of representatives of one dozen exemplary home-based medical practices (home-based primary care and home-based palliative care), professional societies (the American Academy of Home Care Medicine, the American Academy of Hospice and Palliative Medicine, and the American Geriatrics Society), and patient advocacy groups (the Kaiser Family Foundation, the National Partnership for Women and Families, and the American Association of Retired Persons [AARP]). We developed our Network, in 2013, in the recognition that approximately four million vulnerable adults in the United States have difficulty obtaining or are completely unable to access office-based primary care because they are frail, functionally limited, and homebound. They are among the most costly patients in the US health care system, not because of a specific disease but because of a powerful combination of multiple chronic conditions, functional impairment, frailty, and social stressors. These patients account for approximately half of the costliest 5 percent of patients. Approximately 10% of homebound persons currently receive care through the provision of home-based medical care by physicians, nurse practitioners, and interdisciplinary care teams.¹

Home-based medical care is likely to continue to grow in the wake of the Affordable Care Act (ACA), which creates strong incentives for financially at-risk organizations—such as accountable care organizations, Medicare Advantage plans, and Medicaid managed care plans—to incorporate home-based medical care into their population health strategies, with hopes of achieving the Triple Aim for health care. Furthermore, the success of the first year of the Independence at Home Demonstration,

¹ Ornstein KA, Leff B, Covinsky KE, Ritchie CS, Federman AD, Roberts L, Kelley AS, Siu AL, Szanton SL. Epidemiology of the Homebound Population in the United States. *JAMA Intern Med.* 2015 Jul;175(7):1180-6. doi:10.1001/jamainternmed.2015.1849. Erratum in: *JAMA Intern Med.* 2015 Aug;175(8):1426. PubMed PMID: 26010119.

detailed in section 3024 of the ACA and managed by the Center for Medicare and Medicaid Innovation, may further encourage home-based medical care development. We strongly support the expansion of the Independence at Home Demonstration.

Despite the increasing use of home-based medical care, there is currently no quality-of-care framework or set of nationally recognized and widely used quality measures for home-based medical care practices. As a result, payers lack knowledge of the unique care needs of the population that could benefit from homebased medical care and of how such practices are designed. Payers also lack data to help them judge the quality of care provided by a practice. Home-based medical care providers (physicians and nurse practitioners) who are interested in benchmarking their own practices are forced to use available quality metrics, most of which are specific to a single disease. These generic measures for single conditions might create performance incentives to provide the wrong type of care for high-need and high-cost patients with multiple morbidities, who often have limited life expectancy. Home-based medical practices also lack the infrastructure to engage with national performance reporting efforts. In the wake of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), this inability may soon result in serious challenges for these struggling home-based primary care practices.

Ensuring that high-quality medical care is provided in the home is difficult because no widely used patient-centered quality-of-care framework exists for home-based medical care practices. The National Quality Forum (NQF) has not endorsed any measures of process and outcome that are specific to patients served by homebased medical care, in contrast to the situation of patients served in other care venues such as the acute care hospital or nursing home.

To address this problem our Network, using a rigorous approach, has developed an initial set of quality metrics for home-based medical care.² We are taking two approaches to move those measures into value-based care in a manner congruent with MACRA. First, we are creating a CMS-certified Qualified Clinical Data Registry (QCDR). Second, we will pursue NQF endorsement of our measures.

Specific Comments on the “Developing Quality Measure for Chronic Conditions” section (beginning on page 22)

It is in this context that we wish to comment on the “Developing Quality Measure for Chronic Conditions” section (beginning on page 22) of the Bipartisan Chronic Care Working Group Policy Options Document.

We are pleased that the chronic care working group is considering requiring that CMS include in its quality measures plan the development of measures that focus on the health care outcomes for individuals with chronic disease. **However, we think it critical that the requirement call out for the development of measures on persons with *multiple* chronic conditions.** Persons with multiple conditions are quite different from those with a single condition. There is a substantial body of research that demonstrates that chronic conditions are far more common to occur in the presence of other conditions and diseases than they are to appear alone.³ That is, someone with chronic heart failure who has only chronic heart failure and no other chronic disease or conditions is among the minority of

² Leff B, Carlson CM, Saliba D, Ritchie C. The invisible homebound: setting quality-of-care standards for home-based primary and palliative care. *Health Aff (Millwood)*. 2015 Jan;34(1):21-9. doi: 10.1377/hlthaff.2014.1008. PubMed PMID:25561640.

³ Weiss CO, Boyd CM, Yu Q, Wolff JL, Leff B. Patterns of prevalent major chronicdisease among older adults in the United States. *JAMA*. 2007 Sep12;298(10):1160-2. PubMed PMID: 17848649.

people with chronic heart failure. It has been well demonstrated that following multiple single disease-based guidelines and quality measures in someone with multiple conditions commonly leads to harm as guideline may offer conflicting and harmful advice as they do not consider the presence of other conditions.⁴

In addition, **we suggest that the requirement of CMS acknowledge and focus on development of measures and collaborate with groups that have worked on developing measures for the homebound population.** As noted above, these persons account for approximately half of the costliest 5 percent of patients. They require a unique type of care delivery, home-based medical care, which has been shown to be cost effective. Given the nature and characteristics of this population, as well as the nature of home-based medical care, it is important to develop quality measures for this field that attend to both patients and their caregivers and the processes and outcomes of home-based medical care. Further, we suggest that the **requirement for the development of measures on persons with chronic disease should not restrict itself to diseases, per se. The language should include diseases and conditions.** There are a number of conditions that are not categorized as disease that have been shown to be more impactful to health outcomes than diseases.⁵ For instance, functional impairment, which is not well captured in medical encounters, has a profound effect on people’s health service utilization, health outcomes, and health-related costs in the presence of chronic disease.

With regard to the list of topic areas related to chronic conditions that the working group is specifically considering, we would suggest, based on our research, expanding this list. In our development work on measures for home-based medical care, our Network developed quality of care domains (large buckets) and quality of care standards (sub-buckets) appropriate for the homebound population. We then mapped all existing NQF-endorsed quality measures to those quality standards. In this process we found that there were multiple quality standards to which we could map any NQF-endorsed measure. We called these Quality Gap Areas for home-based medical care. We suggest that working group include these gap areas for additional quality measure development. In the table below, we list the home-based medical care domains and standards. **The measurement gap areas are in underlined and bolded.**

Domain	Standard
Assessment	<ul style="list-style-type: none"> Perform a comprehensive assessment that includes the patient’s symptoms (physical, emotional, social, spiritual); physical, executive, and cognitive function; health literacy; goals and sources of meaning and purpose; and care coordination needs, as well as <u>the treatment burden experienced by patient and caregivers</u>; the patient’s and caregivers’ stressors; social support and social risk; and safety concerns
Care coordination	<ul style="list-style-type: none"> Coordinate handoffs between care settings Communicate the patient’s treatment goals and preferences across settings <u>Identify and use appropriate community resources</u>

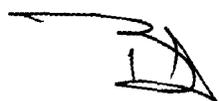
⁴ Boyd CM, Darer J, Boulton C, Fried LP, Boulton L, Wu AW. Clinical practice guidelines and quality of care for older patients with multiple comorbid diseases: implications for pay for performance. JAMA. 2005 Aug 10;294(6):716-24. PubMed PMID: 16091574.

⁵ Schnell K, Weiss CO, Lee T, Krishnan JA, Leff B, Wolff JL, Boyd C. The prevalence of clinically-relevant comorbid conditions in patients with physician-diagnosed COPD: a cross-sectional study using data from NHANES1999-2008. BMC Pulm Med. 2012 Jul 9;12:26. doi: 10.1186/1471-2466-12-26. PubMed PMID: 22695054; PubMed Central PMCID: PMC3461433.

Domain	Standard
	<ul style="list-style-type: none"> • <u>Ensure that all team members have access to key patient information</u> • <u>Ensure that the team is notified of sentinel events</u>
Safety	<ul style="list-style-type: none"> • Perform and document medication reconciliation • Prevent falls and other home-related injuries • Optimize safety in patients with cognitive impairment • <u>Address abuse and neglect</u>
Quality of life	<ul style="list-style-type: none"> • <u>Optimize comfort and safety of the home environment</u> • Optimize symptom management • <u>Reduce treatment burden</u> • Employ preventive services to optimize function
Provider competency	<ul style="list-style-type: none"> • <u>Know how to manage medical problems in the home</u> • <u>Engage in effective interpersonal communication</u>
Goal attainment	<ul style="list-style-type: none"> • Align patient's and caregivers' goals with the care plan • Facilitate communication about and achievement of realistic goals for care
Education	<ul style="list-style-type: none"> • Use knowledge of patient's goals and learning needs to inform the education plan • Promote the patient's and caregivers' understanding of all aspects of the care plan • Mutually determine an emergency contingent plan for care • <u>Support the patient's and caregivers' self-management</u>
Access	<ul style="list-style-type: none"> • Provide timely initiation of care • Provide 24/7 access to urgent care • Ensure and coordinate access to specialty care and home-directed ancillary services • <u>Involve medicine, social work, and nursing at least in the provision of patient care</u>
Patient and caregiver experience	<ul style="list-style-type: none"> • Facilitate trust among the patient, caregivers, and the care team • Manage the patient's and caregivers' stressors • Minimize wait time for non-urgent visits
Cost or affordable care	<ul style="list-style-type: none"> • <u>Match enrollment in home-based medical care program to patient's selection criteria</u> • Measure health care use • Attend to the patient's and caregivers' financial concerns related to health care

Thank you for the opportunity to comment on the work of the Bipartisan Chronic Care Working Group and to be part of this important effort of improving the Medicare program.

Respectfully submitted,



Bruce Leff, MD
 Professor of Medicine
 Johns Hopkins University School of Medicine
 The National Home-Based Primary Care and Palliative Care Network
bleff@jhmi.edu
 410.550.2654



Christine Ritchie, MD, MSPH

Professor of Medicine

University of California San Francisco School of Medicine

The National Home-Based Primary Care and Palliative Care Network

Christine.ritchie@ucsf.edu

(415) 562-2513